

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7506	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/12/2013
NAME OF PROVIDER OR SUPPLIER NORTHSIDE HEALTH CARE NURSING AND RE		STREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST MTCS ROAD MURFREESBORO, TN 37130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 001	<p>1200-8-6 Initial Comments</p> <p>This Rule is not met as evidenced by: During complaint investigation #32024, conducted on August 12-13, 2013, at Northside Health Care Nursing and Rehabilitation Care of Murfreessboro, no deficiencies were cited in relation to the complaint under chapter 1200-8-6, Standards for Nursing Homes.</p>	N 001		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE